Joints In Motion
Physical Therapy & Rehabilitation

First Name _____ M.I. ____ Last Name _____

Address _____ Apt _____

City _____ State _____ Zip _____

Phone# (Home) _____ (Cell) _____

Social Security # _____ Date of Birth _____ Age _____

Single ☐ Married ☐ Divorced ☐ Other ☐ Employed ☐ FT Student ☐ PT Student ☐

Emergency Contact

Name _____ Address _____

Phone _____ Relationship to Patient _____

Physician Information

Referring Doctor's Name _____ Phone _____

Primary Care Physician _____ Phone _____

Work's Comp/No Fault Info

Is injury due to: Auto Accident ☐ Work ☐ Other _____ Date of Injury _____ Date of Surgery _____

Employer _____ Occupation _____

Employer Address _____ Phone _____

How did you hear about us?

Been here before☐ Doctor ☐ Insurance Book☐ Phone Book☐ Internet ☐ Friend/Relative ☐

Other_____

Appointment Reminders

We can remind you either through email, automated phone call or text message.
Please pick one that better serves you.

☐ Opt- In Text Message Reminders……..…Cell Number: _____

☐ Opt- In Phone Call Reminders…….. Phone Number: _____

☐ Opt- In Email Reminders……..…....Email Address: _____

Patient's/Guardian's Signature:_____**Date:** _____

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Payments

Please note this information regarding your benefits is relayed to us by your insurance company & is not a guaranteed. Upon receiving your Explanation of Benefits, your co-pay may change and you are responsible for any difference.

Co-Payment responsibility due each visit: _____ **Cash Rate: First Visit** _____

Co-Insurance responsibility due each visit: _____ **Return Visits** _____

Deductible:_____ **(Office staff to fill out only)**

Consent of Treatment

The undersigned hereby authorize Joints In Motion Physical Therapy and Rehabilitation, PLLC to provide professional services to me/my child/my legal ward. I understand as a patient, I am under the care and control of my physician(s) and that Joints In Motion Physical Therapy and Rehabilitation, PLLC is not liable for any act or omission when providing treatment in accordance with my physician's instructions.
I acknowledge that no guarantee or assurance has been, nor can be made by Joints In Motion Physical Therapy and Rehabilitation, PLLC as to the result of the prescribed treatment.

No-Show/Cancellation Fee

There is a $25.00 Fee

All appointments must be canceled the day prior to your appointment or by the end of the business day on Friday for a Monday appointment, to avoid charges for a no-show or late cancellation.
After hour messages regarding cancellations maybe left at 718-652-3432.
If you for see difficulty maintaining your appointments, please speak with your therapist as accommodations can be made for you.
Insurance will not cover charges for no-show/late-cancellation fees.

Patient Acknowledgement of Receipt of HIPAA Notice

I acknowledge that I have received or have been offered a copy of Joints In Motion Physical Therapy and Rehabilitation, PLLC's Notice of Privacy Practices, effective April 14, 2003. I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Joints In Motion Physical Therapy and Rehabilitation, PLLC may refuse to accommodate my request if it is not reasonable.***A current Notice of Privacy Practices for Joints In Motion Physical Therapy and Rehabilitation, PLLC is also available at the check-in counter.**

Thank You.
Please sign below indicating you understand our policy:

Patient's/Guardian Signature:_____ **Date:** _____

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Health History Questionnaire

Please place an X in any boxes that apply to you, whether a current problem or in the past.

☐ Irregular heart beat	☐ Angina	☐ Pacemaker	☐ Heart surgery
☐ Heart attack	☐ Heart valve problem	☐ High blood pressure	☐ High cholesterol
☐ Asthma	☐ Emphysema	☐ Chronic bronchitis	☐ Hay fever
☐ Bleeding disorders	☐ Kidney disorder	☐ Seizures	☐ Cancer

☐ Arthritis ☐ Broken bones, where? _____

☐ Osteoporosis ☐ Muscle or nerve diseases, specify _____

☐ Diabetes

Do you take insulin?..... ☐ Yes ☐ No If yes, how often do you check your glucose?_____

☐ Gastrointestinal disorder, please specify: _____

☐ Other problem/surgery: _____

Have you ever become weak or ill when exposed to high temperatures?.....☐ Yes ☐ No

Has anybody in your family had a heart attack?.....☐ Yes ☐ No

Do you smoke?.....☐ Yes ☐ No Packs per day?_____

Have you fallen in the last year?.....☐ Yes ☐ No If yes, how many times?_____

Did you receive medical attention when you fell?.....☐ Yes ☐ No ☐ NA

Have you ever received physical therapy?.....☐Yes ☐No For what purpose? _____

Medications: _____

_____

Patient's Signature_____ **Date:** _____

Therapist's Signature_____ _____ **Date:** _____